Recurrent Pancreatitis Secondary to Adderall Use with Pancreatic Ascites: A Sight Typically Unseen

Shabari M. Shenoy MBBS[1], Jenny Dave MD[2], Edward Lung MD[2], Kimberly Cavaliere MD[2]

1- Department of Medicine, Mount Sinai Morningside- West Hospital

2- Division of Gastroenterology, Mount Sinai Morningside-West Hospital

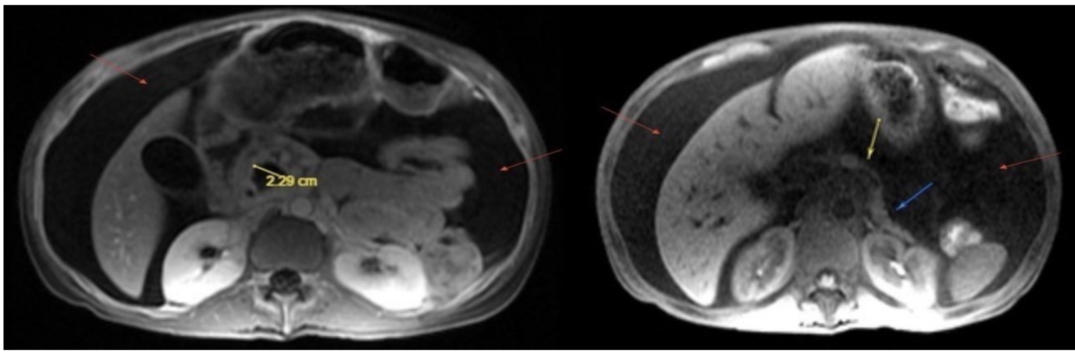
BACKGROUND

- Pancreatic ascites is a rare disease with a prevalence of 3.5% resulting from pancreatic duct injury.
- While small ascites resolves spontaneously, large volume, persistent ascites can cause significant morbidity and mortality.
- We present a case of pancreatic ascites in a patient with recurrent pancreatitis from Adderall use.

CASE

- 38-year-old female with attention deficit hyperactive disorder (ADHD), remote alcohol use, and recurrent pancreatitis complicated by pseudocyst and ascites presented with acute on chronic epigastric pain.
- Her last reported alcohol use was two years ago. Home medications included Adderall (amphetamine and dextroamphetamine) and benzodiazepines.
- Physical examination revealed normal vital signs, severe cachexia and peripheral edema. Abdomen was distended with epigastric tenderness.
- Pertinent labs included hemoglobin of 10.8g/dl, calcium 7.6mg/dl, albumin 1.7g/dl and a lipase of 462U/l. Bilirubin, transaminases, alkaline phosphatase and INR were normal.

CASE



- Quantitative immunoglobulins, IgG4, triglycerides and thyroid stimulating hormone were within normal limits. Blood alcohol and phosphatidylethanol (PETH) levels were negative.
- Previous CT scan demonstrated pancreatic head cyst (4.6cm), stable pseudocysts in the head and body, peripancreatic inflammation and large abdominal ascites. MRCP this admission revealed pancreatic head fluid collection decreased in size (yellow arrow), consistent with walled off necrosis, pancreatic inflammation (blue arrow) and ascites (red arrows).
- Diagnostic paracentesis was significant for: WBC 93 cells/mm^3, PMN 25%, RBC 2050 cells/mm^3, protein 1.9 g/dl, lactate dehydrogenase 102 U/L, amylase 1496 U/L and a serum ascites-albumin gradient (SAAG) < 1.1.
- An endoscopic retrograde cholangiopancreatography (ERCP) was pursued due to suspicion for pancreatic ascites which showed abrupt cut off of the pancreatic duct in the head, without filling of the pancreatic duct in the body or tail likely due to stricture.
- A pancreatic stent was placed into the ventral pancreatic duct to maintain patency.
- EUS was performed and a stent was placed by cystogastrostomy.

CONCLUSIONS

- Pancreatic ascites is often seen with recurrent pancreatitis commonly of alcoholic etiology.
- Our patient had recurrent pancreatitis and ascites due to chronic adderall use.
- While pancreatitis from adderall use is rare, presentation with ascites can pose a diagnostic challenge.
- Hence, clinicians should familiarize themselves with early diagnosis and endoscopic management which improves prognosis in this rare disease.

REFERENCES

1. Sankaran S, Walt AJ. Pancreatic Ascites: Recognition and Management. *Arch Surg*. 1976;111(4):430–434. doi:10.1001/archsurg.1976.01360220126021